SERFF Tracking Number:	*CMPL-125745279*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39786*
Company Tracking Number:	*TRANS APP II FORM APA711008T LIFE INS APPL*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Trans App II Form APA711008T Life Ins Appl*		
Project Name/Number:	*Trans App II Form APA711008T Life Ins Appl/Trans App II Form APA711008T Life Ins Appl*		

Filing at a Glance

Company: Transamerica Life Insurance Company

Product Name: Trans App II Form APA711008T Life Ins Appl	SERFF Tr Num: CMPL-125745279	State: ArkansasLH
TOI: L09I Individual Life - Flexible Premium Adjustable Life	SERFF Status: Closed	State Tr Num: 39786
Sub-TOI: L09I.001 Single Life	Co Tr Num: TRANS APP II FORM APA711008T LIFE INS APPL	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Author: Nancy French	Disposition Date: 08/01/2008
	Date Submitted: 07/30/2008	Disposition Status: Approved
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Trans App II Form APA711008T Life Ins Appl	Status of Filing in Domicile:
Project Number: Trans App II Form APA711008T Life Ins Appl	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 08/01/2008	
State Status Changed: 08/01/2008	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Re: Transamerica Life Insurance Company

NAIC #86231-468 FEIN #39-0989781

Form APA461008T, Individual Life Application, Part 1

SERFF Tracking Number:	*CMPL-125745279*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39786*
Company Tracking Number:	*TRANS APP II FORM APA711008T LIFE INS APPL*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Trans App II Form APA711008T Life Ins Appl*		
Project Name/Number:	*Trans App II Form APA711008T Life Ins Appl/Trans App II Form APA711008T Life Ins Appl*		

Form APA481008T, Life Insurance Application

Form APA711008T, Life Insurance Application

Dear Commissioner:

This filing is being submitted by Compliance Research Services, LLC on behalf of Transamerica Life Insurance Company (Transamerica). A letter of filing authorization is enclosed.

Please find enclosed the above-referenced forms for your review and approval. The forms are single life applications for use in connection with Transamerica's individual universal life policies. The forms are new and do not replace any forms currently on file with your Department.

Application APA461008T will be submitted for full underwriting. Application APA481008T will be used for conditional guaranteed issue underwriting. And application APA711008T will used with conditional simplified issue. In this third application, the #3 Beneficiary section is bracketed for recording more than one beneficiary, as necessary. The display of underwriting questions #14 through #21 will vary by the underwriting class being selected by the policy owner. Everyone in a given class will have the same questions on the application they complete.

The enclosed applications are not intended to change the risk and will not result in changes in any rates or actuarial data previously approved.

The forms are in final printed format. Transamerica reserves the right to change the type style and paper size. Transamerica also plans to make these forms available electronically. It is their intent to use the forms in a variety of electronic environments, including laptop and web based application process. Regardless of the application process used, Transamerica will adopt measures to secure both the integrity of the document once signed, and the confidentiality of any information transmitted, including transmission of information via secured socket layer/secured line. Information contained in the application will be transmitted to Transamerica's administrative office electronically as well as the electronic signature of the Owner/Applicant. Current technology will be used to ensure that the confidential information is not compromised. All processes used will comply with the Uniform Electronic Transactions Act, and to the extent applicable, the Federal ESIGN Act.

SERFF Tracking Number:	*CMPL-125745279*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39786*
Company Tracking Number:	*TRANS APP II FORM APA711008T LIFE INS APPL*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Trans App II Form APA711008T Life Ins Appl*		
Project Name/Number:	*Trans App II Form APA711008T Life Ins Appl/Trans App II Form APA711008T Life Ins Appl*		

Transamerica hereby certifies that any electronic signature it obtains will be linked to the data on the electronic application in such a manner that the electronic signature is invalidated if any of the data on the application is changed. Transamerica also certifies that such electronic signature intended for use with these applications will not be affixed to or duplicated on any other document. A copy of the application, identical to the filed form, will be printed and made part of any policy issued.

All required forms and transmittals are included with this submission.

You may direct any questions or comments regarding this submission to me at 513-984-6050 or e-mail me at dsimon@crssolutionsgroup.com.

Sincerely,

J. David Simon, CLU
President

Company and Contact

Filing Contact Information
(This filing was made by a third party - complianceresearchservicesllc)

Nancy French, Product Manager	nfrench@crssolutionsgroup.com
10921 Reed Hartman Highway	(513) 984-6050 [Phone]
Cincinnati, OH 45242	(513) 984-7212[FAX]

Filing Company Information

Transamerica Life Insurance Company	CoCode: 86231	State of Domicile: Iowa
4333 Edgewood Road N.E.	Group Code: 468	Company Type:

SERFF Tracking Number:	*CMPL-125745279*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39786*
Company Tracking Number:	*TRANS APP II FORM APA711008T LIFE INS APPL*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Trans App II Form APA711008T Life Ins Appl*		
Project Name/Number:	*Trans App II Form APA711008T Life Ins Appl/Trans App II Form APA711008T Life Ins Appl*		

Cedar Rapids, IA 52499
(513) 984-6050 ext. [Phone]

Group Name:
FEIN Number: 39-0989781

State ID Number:

SERFF Tracking Number:	*CMPL-125745279*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39786*
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Product Name:	*Trans App II Form APA711008T Life Ins Appl*		
Project Name/Number:	*Trans App II Form APA711008T Life Ins Appl/Trans App II Form APA711008T Life Ins Appl*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$60.00
Retaliatory?	No
Fee Explanation:	3 x $20 = 60
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Transamerica Life Insurance Company	$60.00	07/30/2008	21668051

SERFF Tracking Number:	*CMPL-125745279*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39786*
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Product Name:	*Trans App II Form APA711008T Life Ins Appl*		
Project Name/Number:	*Trans App II Form APA711008T Life Ins Appl/Trans App II Form APA711008T Life Ins Appl*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	08/01/2008	08/01/2008

SERFF Tracking Number:	*CMPL-125745279*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39786*
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Product Name:	*Trans App II Form APA711008T Life Ins Appl*		
Project Name/Number:	*Trans App II Form APA711008T Life Ins Appl/Trans App II Form APA711008T Life Ins Appl*		

Disposition

Disposition Date: 08/01/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CMPL-125745279*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39786*
Company Tracking Number:	*TRANS APP II FORM APA711008T LIFE INS APPL*		
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Product Name:	*Trans App II Form APA711008T Life Ins Appl*		
Project Name/Number:	*Trans App II Form APA711008T Life Ins Appl/Trans App II Form APA711008T Life Ins Appl*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	Filing Authorization		Yes
Supporting Document	Statement of Variability		Yes
Supporting Document	Readability		Yes
Form	Life Insurance Application		Yes
Form	Individual Life Application, Part 1		Yes
Form	Life Insurance Application		Yes

SERFF Tracking Number:	*CMPL-125745279*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39786*
Company Tracking Number:	*TRANS APP II FORM APA711008T LIFE INS APPL*		
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Product Name:	*Trans App II Form APA711008T Life Ins Appl*		
Project Name/Number:	*Trans App II Form APA711008T Life Ins Appl/Trans App II Form APA711008T Life Ins Appl*		

Form Schedule

Lead Form Number: APA461008T

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	APA711008T	Application/ Enrollment Form	Life Insurance Application	Initial		51	APA711008T Standard.pdf
	APA461008T	Application/ Enrollment Form	Individual Life Application, Part 1	Initial		51	APA461008T Standard.pdf
	APA481008T	Application/ Enrollment Form	Life Insurance Application	Initial		51	APA481008T.pdf

TRANSAMERICA
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
[4333 Edgewood Road NE
Cedar Rapids, IA 52499]

GA #_____

Application for Individual Life Insurance

1. Proposed Insured (Last Name) (First Name) (Middle Initial) | Organization:

Date of Birth: Month Day Year | Age: | Place of Birth: | ❑ Male ❑ Female

Residence: (Street/City/State/Zip Code/Country/*Cannot be a P.O. Box)* | Daytime Phone:

Social Security No.: | Occupation and Regular Duties: | Annual Salary:

U.S. Citizen ❑ Yes ❑ No If no, complete Residency & Travel Questionnaire. | Hire Date:

2. Owner Name If Trust, provide name and date of Trust: | Relationship to Proposed Insured: | TIN or Soc. Sec. No.:

Address: (Street/City/State/Zip Code/Country/*Cannot be a P.O. Box)* | Date of Birth Month Day Year

Billing Address: (Street/City/State/Zip Code/Country) (If other than above) | (Not for Policy/Billing Notices) E-mail:

U.S. Citizen ❑ Yes ❑ No If no, VISA Type/Immigration Status:

3. Beneficiary Name: | Relationship to Proposed Insured: | TIN or Soc. Sec. No.:

Address: (Street/City/State/Zip Code/Country/*Cannot be a P.O. Box)* | Benefit Split (Share or %) | Date of Trust, if applicable Month Day Year

4. a) Plan of Insurance:_____ **Kind Code:**_____ **Amount Applied For: $**_____

Death Benefit Option for Universal Life (Select only one, default is Level): ❑ Level ❑ Plus ❑ Plus Premium

b) Nicotine Classification: ❑ Nicotine ❑ Non-Nicotine

c) Additional Benefits Applied For: Annual Percentage Increase (Select Only One, default is None)

❑ None ❑ Annual Adjustment Review Option: _____ % (2% to 10%) ❑ Annual Increase Rider: _____ % (3% to 8%)

❑ Supplemental Adjustable Life Insurance Rider: $_____ ❑ Other _____ $_____

d) Premium Payment Mode: ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly List Bill

e) Planned Periodic Premium: $_____ f) If applicable, Required Annual Premium (RAP) $_____

+ Initial Lump Sum $_____ g)Does the initial premium include any 1035 Exchange proceeds:

= Total Initial Payment: $_____ ❑ Yes ❑ No If Yes, Amount: $_____

5) Total insurance in force with all companies: Life Insurance $_____ Accidental Death $_____

Proposed Insured must answer all questions and give details to a no answer to Question 8 and any yes answer to the remaining questions in the Remarks Section on Page 3.

6. Height _____ Weight _____

❑ Yes ❑ No 7. Have you used nicotine at any time in any form? If yes, give dates (month and year) last used and type (cigarettes, cigar, pipe, chewing tobacco, other):_____

❑ Yes ❑ No 8. For at least 30 hours per week, are you actively at work performing the regular duties of your occupation in the usual manner and at the usual place of employment or business?

❑ Yes ❑ No 9. Are you currently partially or totally disabled?

❑ Yes ❑ No 10. Within the last six months, have you missed more than five days of work due to accident or illness?

❑ Yes ❑ No 11. At any time within the last six months, have you been hospitalized or treated by a doctor or a member of the medical profession on an outpatient basis?

❑ Yes ❑ No 12. Have you ever had, been told by a member of the medical profession that you have, or been diagnosed with or treated for any immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus (HIV) or tested positive on an AIDS/HIV-related test?

❑ Yes ❑ No 13. Are you currently taking any medication or have been told to take any medication?

❑ Yes ❑ No 14. Within the past five years have you consulted, been examined or been treated by any physician or medical practitioner?

❑ Yes ❑ No 15. Within the past five years have you had or been advised to have a surgical procedure?

❑ Yes ❑ No 16. Do you suffer from any physical, mental or medical impairment of your ability to perform the duties of any occupation for which you are otherwise qualified by reason of your education, training or experience?

❑ Yes ❑ No 17. Has any application for life, health, disability or long term care insurance been declined, withdrawn, postponed, rated, modified, issued with exclusion rider, cancelled or non-renewed?

❑ Yes ❑ No 18. Do you plan to travel in the next 12 months for business or pleasure to a destination outside the U.S., Canada, Western Europe, Hong Kong, Australia or New Zealand? If yes, complete Residency & Travel Questionnaire.

❑ Yes ❑ No 19. Have you ever been convicted of a felony within the past five years? If yes, provide full details including state and date of offense.

❑ Yes ❑ No 20. In the past five years, have you been convicted of or pleaded guilty to three or more moving violations, been convicted of or pleaded guilty to driving under the influence of alcohol and/or other drugs, or reckless driving? If yes, give dates and type.

❑ Yes ❑ No 21. Have you ever been treated or counseled or been advised to seek treatment or counseling for the use of alcohol, drugs or other substance or joined an organization for alcohol or drug dependence or abuse? If yes, provide details.

FRAUD WARNING

The following state(s) and U.S. territories require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state or U.S. territory as indicated below.

ARKANSAS, LOUISIANA and WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO: Any person who knowingly, and with the intention to defraud, includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony, and if found guilty, shall be punished for each violation with a fine of no less than five thousand dollars ($5000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

TENNESSEE , VIRGINIA and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

ALL OTHER STATES: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Remarks for a no answer to Question 8 and/or any yes answers to remaining questions.

Question Number	Illness, Injury, Disease or Symptoms or Medication	Date (Month/Year) Condition Diagnosed	Duration	Result/Current Health Status/Prognosis

I, the Proposed Insured, and I, the Owner if different, hereby represent that the statements and answers given in this application are true, complete and correctly recorded. **I/we agree:** (1) this application and any required supplement(s)/amendment(s) shall be the basis for any contract issued on this application; (2) any contract issued on this application shall not take effect until after all of the following conditions have been met: (a) the full first premium is paid, (b) the Owner has personally received the contract during the lifetime of and while the Proposed Insured is in good health, and (c) all of the statements and answers given in this application must be true and complete as of the date of Owner's personal receipt of the contract and that the contract will not take effect if the facts have changed; (3) no waiver or modification shall be binding upon Transamerica Life Insurance Company (the Company) unless in writing and signed by the President or a Vice President and the Secretary or an Assistant Secretary.

I/we understand that omissions or misstatements in this application could cause an otherwise valid claim to be denied under any contract issued from this application.

I/WE UNDERSTAND THAT COMPLETION AND SUBMISSION OF THIS APPLICATION IN NO WAY IMPLIES THAT THE PROPOSED INSURED WILL BE ACCEPTED FOR INSURANCE COVERAGE.

NOTICE TO CONSUMER

The death benefit on many business related life insurance policies will be taxable to the extent it exceeds the premiums and other considerations paid by you for the policy under Section 101(j) of the Internal Revenue Code unless written Notice and Consent is obtained **prior to policy issue** and certain other requirements are met. These policies are often referred to as Employer-Owned Life Insurance Policies but can also include policies owned by others such as affiliates and business owners.

You are advised to consult with your qualified tax advisor prior to purchasing this policy.

AUTHORIZATION TO OBTAIN INFORMATION

I, the Proposed Insured, hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insuring or reinsuring company, the MIB Group, Inc. and its members or affiliates, consumer reporting agency, or employer having information available as to testing, diagnosis, treatment and prognosis with respect to any physical or mental condition (for example: coronary disease; cancer; Human Immunodeficiency Virus (HIV) related test results or disorders; metabolic, pulmonary, or neurological disorders) and/or treatment of me and any other non-medical information of me to give to the Company or its legal representative, any and all such information.

I understand the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing contract. Any information obtained will not be released by the Company to any person or organization **except** to reinsuring companies, the MIB Group, Inc. and its members or affiliates, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may authorize.

I know that I may request to receive a copy of this Authorization. **I agree** that a photocopy of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for two and one half years from the date shown below, regardless of my condition and whether I am living or not.

I acknowledge receipt of the Notice of Disclosure of Information.

Signed at _____ on _____ , _____

City-State Date

X _____ X _____

Signature of Proposed Insured (or parent or guardian if Proposed Insured is a minor) Witness to Signature of Proposed Insured

Signed at _____ on _____ , _____

City-State Date

X _____ X _____

Signature of Owner (if other than Proposed Insured) Witness to Signature of Owner

If Owner is a Corporation, an authorized officer, other than the Proposed Insured, must sign as Owner, give corporate title and full name of corporation below.

_____ X _____

Signature of Licensed Producer

_____

_____

NOTICE OF DISCLOSURE OF INFORMATION

Information regarding your insurability will be treated as confidential except that Transamerica Life Insurance Company (the Company) may make a brief report to the MIB Group, Inc. (MIB) and its members or affiliates, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance, or to which a claim is submitted, MIB will supply such company with the information it may have in its files. The Company may also release information in its file to reinsurers and to other life insurance companies to which you may apply for life or health insurance, or to which a claim is submitted.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112, telephone (866) 692-6901 (TTY (866) 346-3642 for hearing impaired).

Notice of Insurance Information Practices: The information collected about you by us may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right of access and correction with respect to the information collected except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact your agent or write the Company at its Administrative Office, [4333 Edgewood Road NE, Cedar Rapids, IA 52499].

TRANSAMERICA® LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: [4333 Edgewood Road NE
Cedar Rapids, IA 52499]

GA # _____

Individual Life Insurance Application For One Life Part 1

Proposed Insured: _____ _____
First Middle Last Suffix Mr./Mrs./Ms./Dr.

Birthdate: _____ Age _____ Birth Place: _____ Male ☐ Female ☐
Mo. Day Yr.

Soc. Sec. No.: _____ U.S. Citizen ☐ Yes ☐ No If no, complete Residency & Travel Questionnaire

Employer: _____ Hire Date: _____ _____
Area Code & Work Phone

Occupation and Regular Duties: _____

Annual Income $ _____ Net Worth $ _____

Residence: _____ _____
No. & Street (*Cannot be a P.O. Box*) City State Zip Country Area Code & Home Phone

Owner's Name: _____ Birthdate: _____
(If other than Proposed Insured) Mo. Day Yr.

If Trust, provide name and date of Trust: _____

Relationship to Proposed Insured: _____

Address: _____ _____
No. & Street (*Cannot be a P.O. Box*) City State Zip Country Soc. Sec. or Tax No.

U.S. Citizen ☐ Yes ☐ No If no, VISA Type/Immigration Status: _____ E-mail: _____
(Not for Policy/Billing Notices)

Beneficiary's Name and Relationship to Proposed Insured: _____

_____

Address: _____ _____
No. & Street (*Cannot be a P.O. Box*) City State Zip Country Date of Trust, if Applicable

1. Plan of Insurance: _____ Kind Code: _____ Amount Applied For: $ _____
2. Death Benefit Option for Universal Life (Select only one, default is Level): ☐ Level ☐ Plus ☐ Plus Premium ☐ Other _____
3. Risk Classification: Preferred/Select Plus ☐ Standard/Select ☐
   Extra Rating of ☐ _____ Other ☐ _____
4. Nicotine Classification: ☐ Nicotine ☐ Non-Nicotine
5. Additional Benefits Applied For: Annual Percentage Increase (Select only one, default is None)
   ☐ None ☐ Annual Adjustment Review Option: _____% (2% to 10%) ☐ Annual Increase Rider: _____% (3% to 8%)
   ☐ Supplemental Adjustable Life Insurance Rider: $ _____ ☐ Other _____ $ _____
6. Premium Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly List Bill
7. Planned Periodic Premium: $ _____ If applicable, Required Annual Premium (RAP) $ _____
   + Initial Lump Sum $ _____ Does the initial premium include any 1035 Exchange proceeds:
   = Total Initial Payment: $ _____ ☐ Yes ☐ No If yes, amount: $ _____
8. Do you have any existing life insurance? If none, check this box ☐. If yes, please list the policies below.

Type of Coverage (Personal / Business / Employer Provided / Group)	Company/Policy Number	Face Amount
		$
		$
		$

a. Total Accidental Death insurance inforce with all companies: $ _____

9. Is any application for life insurance pending with any other company? ☐ Yes ☐ No
If yes, give company name, amount applied for and total amount to be placed. _____

10. Are there any life insurance policies on the life of the Proposed Insured that you do not own, including but not limited to any that you have sold or settled? ☐Yes ☐ No If yes, give insurance company name, owner's name, and amount of insurance of each policy.

_____

11. Mail Additional Premium Notices To: _____

Address: _____
No. & Street City State Zip Country

Yes	No	**"You" means any person proposed to be insured.**
☐	☐	12. Have you ever participated in, or within the next two years do you intend to participate in, hang-gliding, sky diving, parachuting, ultralight flying, vehicle racing, scuba diving, mountain or rock climbing, rodeos, competitive skiing or snowboarding, extreme sports or other hazardous activities? If yes, complete Sports and Hazardous Activities Questionnaire.
☐	☐	13. Do you plan to travel in the next 12 months for business or pleasure to a destination outside the U.S., Canada, Western Europe, Hong Kong, Australia or New Zealand? If yes, complete Residency & Travel Questionnaire.
		14. Have you used nicotine at any time? Date Last Used
☐	☐	Cigarettes _____
☐	☐	Cigar/Pipe/Chewing Tobacco _____
☐	☐	Other _____
		15. Driver's License #: _____ State: _____
		In the past five years, have you been convicted of or pleaded guilty to:
☐	☐	a. Moving violations? If yes, give dates and type. _____
☐	☐	b. Driving under the influence of alcohol and/or other drugs? If yes, give dates. _____
☐	☐	c. Reckless driving? If yes, give dates. _____
☐	☐	16. Except as a passenger on a regularly scheduled flight, has the Proposed Insured flown within the past 2 years, or does the Proposed Insured have plans to fly in the future other than as a passenger? If yes, complete Aviation Questionnaire.
☐	☐	17. Have you ever been convicted of a felony, misdemeanor or infraction other than a traffic violation? If yes, provide full details including state and date of offense.
☐	☐	18. Are you a member of the armed forces including reserves? Intend to become a member? Any deployment orders outside U.S.? If yes, give full details.
☐	☐	19. Is the Proposed Insured currently in bankruptcy or has the Proposed Insured been the subject of any voluntary or involuntary bankruptcy proceeding pending within the last 12 months? If yes, please provide full details including Chapter 7, 11, or 13, date filed, and date of discharge and dismissal, if any.

Remarks: Give details for any questions answered yes

_____

_____

_____

_____

_____

FRAUD WARNING

The following state(s) and U.S. territories require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state or U.S. territory as indicated below.

ARKANSAS, LOUISIANA and WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO: Any person who knowingly, and with the intention to defraud, includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony, and if found guilty, shall be punished for each violation with a fine of no less than five thousand dollars ($5000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

TENNESSEE , VIRGINIA and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

ALL OTHER STATES: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

NOTICE TO CONSUMER

The death benefit on many business related life insurance policies will be taxable to the extent it exceeds the premiums and other considerations paid by you for the policy under Section 101(j) of the Internal Revenue Code unless written Notice and Consent is obtained **prior to policy issue** and certain other requirements are met. These policies are often referred to as Employer-Owned Life Insurance Policies but can also include policies owned by others such as affiliates and business owners.

You are advised to consult with your qualified tax advisor prior to purchasing this policy.

I, the Proposed Insured, and I, the Owner if different, hereby represent that the statements and answers given in this application are true, complete and correctly recorded. **I/we agree:** (1) this application shall consist of Part 1, Part 2, and any required application supplement(s)/amendment(s), and shall be the basis for any contract issued on this application; (2) any contract issued on this application shall not take effect until after all of the following conditions have been met: (a) the full first premium is paid, (b) the Owner has personally received the contract during the lifetime of and while the Proposed Insured is in good health, and (c) all of the statements and answers given in this application must be true and complete as of the date of Owner's personal receipt of the contract and that the contract will not take effect if the facts have changed; (3) no waiver or modification shall be binding upon Transamerica Life Insurance Company (the Company) unless in writing and signed by the President or a Vice President and the Secretary or an Assistant Secretary.

I/we understand that omissions or misstatements in this application could cause an otherwise valid claim to be denied under any contract issued from this application.

I/WE UNDERSTAND THAT COMPLETION AND SUBMISSION OF THIS APPLICATION IN NO WAY IMPLIES THAT THE PROPOSED INSURED WILL BE ACCEPTED FOR INSURANCE COVERAGE.

AUTHORIZATION TO OBTAIN INFORMATION

Transamerica Life Insurance Company (the Company)

I, the Proposed Insured, hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insuring or reinsuring company, the MIB Group, Inc. and its members or affiliates, consumer reporting agency, or employer having information available as to testing, diagnosis, treatment and prognosis with respect to any physical or mental condition (for example: coronary disease; cancer; Human Immunodeficiency Virus (HIV) related test results or disorders; metabolic, pulmonary, or neurological disorders) and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to the Company or its legal representative, any and all such information.

I understand the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing contract. Any information obtained will not be released by the Company to any person or organization **except** to reinsuring companies, the MIB Group, Inc. and its members or affiliates, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may authorize.

I know that I may request to receive a copy of this Authorization. **I agree** that a photocopy of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for two and one half years from the date shown below, regardless of my condition and whether I am living or not.

I acknowledge receipt of the Notice of Disclosure of Information. **I understand** that if an investigative consumer report is ordered in connection with this application, I may elect to be interviewed in connection with the preparation of the report and, upon request, I will be provided with a copy of the report. I elect to be interviewed if an investigative consumer report is prepared. ☐ Yes ☐ No

Signed at _____ on _____ , _____
City-State Date

X _____ X _____
Signature of Proposed Insured (or parent or guardian if Proposed Insured is a minor) Witness to Signature of Proposed Insured

Signed at _____ on _____ , _____
City-State Date

X _____ X _____
Signature of Owner (if other than Proposed Insured) Witness to Signature of Owner

If Owner is a Corporation, an authorized officer, other than the Proposed Insured must sign as Owner, give corporate title and full name of corporation below.

_____ X _____
Signature of Licensed Producer

_____

_____

NOTICE OF DISCLOSURE OF INFORMATION

Information regarding your insurability will be treated as confidential except that Transamerica Life Insurance Company (the Company) may make a brief report to the MIB Group, Inc. (MIB) and its members or affiliates, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance, or to which a claim is submitted, MIB will supply such company with the information it may have in its files. The Company may also release information in its file to reinsurers and to other life insurance companies to which you may apply for life or health insurance, or to which a claim is submitted.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112, telephone (866) 692-6901 (TTY (866) 346-3642 for hearing impaired).

Notice to Persons Applying for Insurance: Federal law requires us to advise you that in connection with this application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. Such reports are usually part of the process of evaluating risks for life and health insurance. Inquiry may be made into your character, general reputation, personal characteristics and mode of living. It is possible that a representative of a firm employed to make such reports may call upon you in person. You have the right to request disclosure of the nature and scope of the investigation by your written request made within a reasonable time after receipt of this notice.

Notice of Insurance Information Practices: The information collected about you by us may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right of access and correction with respect to the information collected except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact your agent or write the Company at its Administrative Office, [4333 Edgewood Road NE, Cedar Rapids, IA 52499].

TRANSAMERICA
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: [4333 Edgewood Road NE
Cedar Rapids, IA 52499]

GA #_____

Application for Individual Life Insurance

1. Proposed Insured (Last Name) (First Name) (Middle Initial)			Organization:
Date of Birth: Month Day Year	Age:	Place of Birth:	❑ Male ❑ Female
Residence: (Street/City/State/Zip Code/Country/*Cannot be a P.O. Box)*			Daytime Phone:
Social Security No.:	Occupation and Regular Duties:		Annual Salary:
U.S. Citizen ❑ Yes ❑ No If no, complete Residency & Travel Questionnaire.			Hire Date:
2. Owner Name If Trust, provide name and date of Trust:	Relationship to Proposed Insured:		TIN or Soc. Sec. No.:
Address: (Street/City/State/Zip Code/Country/*Cannot be a P.O. Box)*			Date of Birth Month Day Year
Billing Address: (Street/City/State/Zip Code/Country) (If other than above)			(Not for Policy/Billing Notices) E-mail:
U.S. Citizen ❑ Yes ❑ No If no, VISA Type/Immigration Status:			
3. Beneficiary Name:	Relationship to Proposed Insured:		TIN or Soc. Sec. No.:
Address: (Street/City/State/Zip Code/Country/*Cannot be a P.O. Box)*			Date of Trust, if applicable Month Day Year

4. a) Plan of Insurance:_____ **Kind Code:**_____ **Amount Applied For: $** _____

Death Benefit Option for Universal Life (Select only one, default is Level): ❑ Level ❑ Plus ❑ Plus Premium

b) Nicotine Classification: ❑ Nicotine ❑ Non-Nicotine

c) Additional Benefits Applied For: Annual Percentage Increase (Select Only One, default is None)

❑ None ❑ Annual Adjustment Review Option:_____ % (2% to 10%) ❑ Annual Increase Rider:_____ % (3% to 8%)

❑ Supplemental Adjustable Life Insurance Rider: $ _____ ❑ Other _____ $ _____

d) Premium Payment Mode: ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly List Bill

e) Planned Periodic Premium: $ _____

+ Initial Lump Sum $ _____

= Total Initial Payment: $ _____

f) If applicable, Required Annual Premium (RAP) $ _____

g) Does the initial premium include any 1035 Exchange proceeds:

❑ Yes ❑ No If Yes, Amount: $ _____

5. Total insurance in force with all companies: Life Insurance $ _____ Accidental Death $ _____

Proposed Insured must answer all questions and provide the requested details for each question.

☐ Yes ☐ No 6. For at least 30 hours per week, are you, the Propsosed Insured, actively at work performing the duties of your regular occupation? If no, give details: _____

☐ Yes ☐ No 7. Within the past 6 months, has the Proposed Insured missed more than 5 days of work due to accident or illness? If yes, give details: _____

☐ Yes ☐ No 8. At any time, has the Proposed Insured used nicotine in any form? If yes, give dates (month and year) last used and type (cigarettes, cigar, pipe, chewing tobacco, other): _____

FRAUD WARNING

The following state(s) and U.S. territories require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state or U.S. territory as indicated below.

ARKANSAS, LOUISIANA and WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO: Any person who knowingly, and with the intention to defraud, includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony, and if found guilty, shall be punished for each violation with a fine of no less than five thousand dollars ($5000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

TENNESSEE , VIRGINIA and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

ALL OTHER STATES: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

NOTICE TO CONSUMER

The death benefit on many business related life insurance policies will be taxable to the extent it exceeds the premiums and other considerations paid by you for the policy under Section 101(j) of the Internal Revenue Code unless written Notice and Consent is obtained **prior to policy issue** and certain other requirements are met. These policies are often referred to as Employer-Owned Life Insurance Policies but can also include policies owned by others such as affiliates and business owners.

You are advised to consult with your qualified tax advisor prior to purchasing this policy.

I, the Proposed Insured, and I, the Owner if different, hereby represent that the statements and answers given in this application are true, complete and correctly recorded. **I/we agree:** (1) this application and any required supplement(s)/amendment(s) shall be the basis for any contract issued on this application; (2) any contract issued on this application shall not take effect until after all of the following conditions have been met: (a) the full first premium is paid, (b) the Owner has personally received the contract during the lifetime of and while the Proposed Insured is in good health, and (c) all of the statements and answers given in this application must be true and complete as of the date of Owner's personal receipt of the contract and that the contract will not take effect if the facts have changed; (3) no waiver or modification shall be binding upon Transamerica Life Insurance Company (the Company) unless in writing and signed by the President or a Vice President and the Secretary or an Assistant Secretary.

I/we understand that omissions or misstatements in this application could cause an otherwise valid claim to be denied under any contract issued from this application.

I/WE UNDERSTAND THAT COMPLETION AND SUBMISSION OF THIS APPLICATION IN NO WAY IMPLIES THAT THE PROPOSED INSURED WILL BE ACCEPTED FOR INSURANCE COVERAGE.

AUTHORIZATION TO OBTAIN INFORMATION

Transamerica Life Insurance Company (the Company)

I, the Proposed Insured, hereby authorize any insuring or reinsuring company, the MIB Group, Inc. and its members or affiliates, consumer reporting agency, or employer having information available as to testing, diagnosis, treatment and prognosis with respect to any physical or mental condition (for example: coronary disease; cancer; metabolic, pulmonary, or neurological disorders; or Human Immunodeficiency Virus (HIV) related test results or disorders) and/or treatment of me and any other non-medical information of me to give to the Company or its legal representative, any and all such information.

I understand the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing contract. Any information obtained will not be released by the Company to any person or organization **except to** reinsuring companies, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may authorize.

I know that I may request to receive a copy of this Authorization. **I agree** that a photocopy of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for two and one half years from the date shown below, regardless of my condition and whether I am living or not.

I acknowledge receipt of the Notice of Disclosure of Information.

Signed at _____ on _____ , _____
City-State Date

X _____ X _____
Signature of Proposed Insured (or parent or guardian if Proposed Insured is a minor) Witness to Signature of Proposed Insured

Signed at _____ on _____ , _____
City-State Date

X _____ X _____
Signature of Owner (if other than Proposed Insured) Witness to Signature of Owner

If Owner is a Corporation, an authorized officer, other than the Proposed Insured, must sign as Owner, give corporate title and full name of corporation below.

_____ X _____
Signature of Licensed Producer

_____

_____

NOTICE OF DISCLOSURE OF INFORMATION

Information regarding your insurability will be treated as confidential except that Transamerica Life Insurance Company (the Company) may make a brief report to the MIB Group, Inc. (MIB) and its members or affiliates, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance, or to which a claim is submitted, MIB will supply such company with the information it may have in its files. The Company may also release information in its file to reinsurers and to other life insurance companies to which you may apply for life or health insurance, or to which a claim is submitted.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112, telephone (866) 692-6901 (TTY (866) 346-3642 for hearing impaired).

Notice of Insurance Information Practices: The information collected about you by us may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right of access and correction with respect to the information collected except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact your agent or write the Company at its Administrative Office, [4333 Edgewood Road NE, Cedar Rapids, IA 52499].

SERFF Tracking Number:	*CMPL-125745279*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39786*
Company Tracking Number:	*TRANS APP II FORM APA711008T LIFE INS APPL*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Trans App II Form APA711008T Life Ins Appl*		
Project Name/Number:	*Trans App II Form APA711008T Life Ins Appl/Trans App II Form APA711008T Life Ins Appl*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CMPL-125745279*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39786*
Company Tracking Number:	*TRANS APP II FORM APA711008T LIFE INS APPL*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Trans App II Form APA711008T Life Ins Appl*		
Project Name/Number:	*Trans App II Form APA711008T Life Ins Appl/Trans App II Form APA711008T Life Ins Appl*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 07/23/2008

Comments:

Attachment:

AR_AR Certif of Compliance with Rule 19.pdf

Review Status:

Satisfied -Name: Application 07/23/2008

Comments:

This is an application only submission.the forms are new.

Review Status:

Bypassed -Name: Health - Actuarial Justification 07/23/2008

Bypass Reason: This is an application only submission.the forms are new.

Comments:

Review Status:

Bypassed -Name: Outline of Coverage 07/23/2008

Bypass Reason: This is an application only submission.the forms are new.

Comments:

Review Status:

Satisfied -Name: Filing Authorization 07/30/2008

Comments:

Attachment:

TLIC - Multi-Form All DOIs 7-18-08.pdf

Review Status:

Satisfied -Name: Statement of Variability 07/30/2008

Comments:

Attachment:

SERFF Tracking Number:	*CMPL-125745279*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39786*
Company Tracking Number:	*TRANS APP II FORM APA711008T LIFE INS APPL*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Trans App II Form APA711008T Life Ins Appl*		
Project Name/Number:	*Trans App II Form APA711008T Life Ins Appl/Trans App II Form APA711008T Life Ins Appl*		

Applications 2 - Statement of Variability.pdf

SERFF Tracking Number:	*CMPL-125745279*	*State:*	*Arkansas*
Filing Company:	*Transamerica Life Insurance Company*	*State Tracking Number:*	*39786*
Company Tracking Number:	*TRANS APP II FORM APA711008T LIFE INS APPL*		
TOI:	*L09I Individual Life - Flexible Premium Adjustable Life*	*Sub-TOI:*	*L09I.001 Single Life*
Product Name:	*Trans App II Form APA711008T Life Ins Appl*		
Project Name/Number:	*Trans App II Form APA711008T Life Ins Appl/Trans App II Form APA711008T Life Ins Appl*		

Review Status:

Satisfied -Name: Readability 07/30/2008

Comments:

Attachment:

Readability Transamerica Life Insurance Company.pdf

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: **Transamerica Life Insurance Company**

Form Number(s): Form APA461008T, Individual Life Application, Part 1
Form APA481008T, Life Insurance Application
Form APA711008T, Life Insurance Application

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

Signature of Company Officer

Cheryl Bock
Name

Assistant Vice President, Director
Product Implementation
Title

7-29-2008
Date

TRANSAMERICA
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
4333 Edgewood Road NE
Cedar Rapids, Iowa 52499

July 18, 2008

NAIC Company Code: 468-86231

RE: Individual Life Insurance Forms

To: All Departments of Insurance

Transamerica Life Insurance Company hereby authorizes Compliance Research Services, LLC, to represent us in the submission of individual life insurance forms including policies, applications, riders, endorsements, and related forms, and to negotiate with insurance departments for their approval of said forms.

Sincerely,

Cheryl Bock
Assistant Vice President, Contract Development
Transamerica Life Insurance Company

Statement of Variability
Transamerica Life Insurance Company
NAIC #86231-468 FEIN #39-0989781

Forms:

APA461008T, Individual Life Application, Part 1
APA481008T, Life Insurance Application
APA711008T, Life Insurance Application

Variable text in these forms includes:

1. The company address (4333 Edgewood Road, N.E., Cedar Rapids, Iowa 52499). This appears in the header of the first page and at the end of the Notice of Disclosure of Information of each form.
2. On Form APA711008T, the Beneficiary section is bracketed for expanding to record more than one beneficiary, as necessary. The display of underwriting questions #14 through #21 will vary by the underwriting class being selected by the policy owner. Everyone in a given class will have the same questions on the application they complete.

Transamerica Life Insurance Company

New – Application form filing

READABILITY CERTIFICATION

This is to certify that the form(s) listed below have achieved at least the minimum required score on the Flesch Reading Ease Test.

	Score
Form APA461008T, Individual Life Application, Part 1	51.1
Form APA481008T, Life Insurance Application	51.15
Form APA711008T, Life Insurance Application	51.46

Cheryl Bock

Assistant Vice President, Director,
Product Implementation
319-355-4240